Presurgical Patient Survey

For office use only:

Patient no.: ____________________

Intensity (#6): ____________________

Relief (#7): ____________________

MD Signature: ____________________

Date: ____________________

Patient name: ____

Date: ____

Surgical procedure: ____

Scheduled surgery date: ____

SECTION I

1. Do you have any ongoing pain problems?
yes ☐ *or* **no** ☐ If you answered **yes**, please indicate what those problems are: ____________

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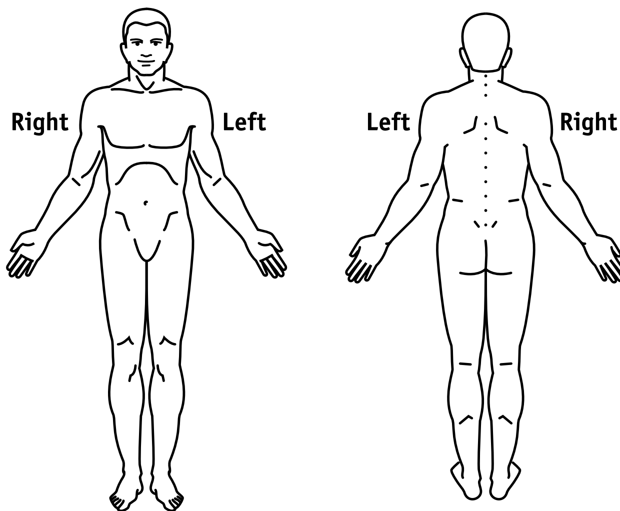
2. If you responded **yes** to question 1, please shade in the areas where pain occurs. Put an X on the area that hurts the most.



3. What medications or other treatments are you receiving for your pain? ____________________

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4. Do these medications or other treatments control your pain to your satisfaction? **yes** ☐ *or* **no** ☐

5. If you responded **no** to question 4, please indicate why: ____________________

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SECTION II

6. On a scale of 0 to 10 (0 = *none,* 10 = *greatest*), please rate the intensity of pain you anticipate after surgery. ____________________

7. On a scale of 0 to 10 (0 = *none,* 10 = *greatest*), how much pain relief do you expect to receive from medications after surgery? ____________________

8. Answering **yes** or **no**, please indicate if you believe that pain after surgery will interfere with your:

A. General activity **yes** ☐ *or* **no** ☐

B. Mood **yes** ☐ *or* **no** ☐

C. Walking ability **yes** ☐ *or* **no** ☐

D. Normal work (including both work outside the home and housework) **yes** ☐ *or* **no** ☐

E. Relations with other people **yes** ☐ *or* **no** ☐

F. Sleep **yes** ☐ *or* **no** ☐

G. Enjoyment of life **yes** ☐ *or* **no** ☐

9. Please indicate any specific questions or concerns you have regarding pain after surgery. ____________________

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